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STATISTICAL BULLETIN
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A LIFE TABLE FOR THE YEAR OF THE INFLUENZA PANDEMIC, 1918

It should be of public interest to observe what effect a devastating epidemic, such as occurred in 1918, would have on the longevity of the population, if, instead of occurring as a transitory outburst, the condition persisted as a constant situation in our mortality. In that year, the whole world was visited by an influenza pandemic which, for intensity, broke all records in the modern civilized world. The best measure of what such a mortality would mean for us if it existed as a permanent state of affairs, is a life table constructed upon the deathrates observed during the year 1918. Such a life table has been computed. It shows that white males might expect a mean length of life of 47.1 years and white females 50.2 years. These are the average after-lifetimes that would obtain if the conditions of 1918 continued throughout the generation. In contrast with this epidemic year, we find that in 1922, which was relatively free from influenza, the average after-lifetime for males was 56.8 years and that for females 59.0 years.

We may, therefore, conclude that a mortality such as that of 1918, if continued over a series of years, would have represented a shortening of life by at least nine years, as compared with conditions current at that time. While in one sense this is a striking expression of the seriousness of the epidemic of 1918, yet in another way the figures thus arrived at bring also a more pleasing lesson. For, if we examine our records of earlier life tables, we find that in the year 1901 the *normal* expectation of life in the absence of any special epidemic, was 48.2 years, for white males, and 51.1 years for white females. Thus the influenza epidemic of 1918, bad as it was, merely brought about a temporary situation which, measured in terms of mean length of life, was but little worse than the constant and current situation in the original registration states at the beginning

of the present century, and no worse than for certain cities in much more recent years. As a matter of fact, some individual districts, even as late as 1910, had a mean length of life no better than that for the registration states in the influenza year, 1918. Thus for the aggregate of cities in the original registration states in 1910, the mean length of life for white males was only 47.3, for females 51.4; and for Pittsburgh even in the year 1920 it was only 47.2 for white males, 50.5 for white females, figures practically identical with the corresponding mean length of life computed for the entire registration states in 1918, the influenza year.

Expectation of Life at Several Ages According to Mortality of 1918 (Influenza Year), in the United States Registration States compared with that of other periods and localities

Age	United States Registration States, 1918		United States Registration States, 1922		United States Original Registration States, 1901		Aggregate of Cities, Original Registration States, 1910		City of Pittsburgh, 1920	
	White Males	White Females	Males	Females	White Males	White Females	White Males	White Females	White Males	White Females
0...	47.07	50.16	56.76	59.01	48.23	51.08	47.32	51.39	47.18	50.51
7...	48.41	50.72	56.69	57.84	53.03	54.62	51.62	54.73	50.38	52.10
12...	44.16	46.54	52.26	53.32	48.85	50.40	47.37	50.44	46.23	47.95
17...	40.17	42.51	47.90	48.92	44.57	46.14	43.00	46.03	41.93	43.67
22...	36.74	39.19	43.80	44.83	40.71	42.26	38.91	41.87	38.06	39.78
27...	33.77	36.58	39.76	40.83	37.06	38.60	34.95	37.87	34.38	36.30
32...	31.34	34.07	35.68	36.82	33.43	34.98	31.09	33.97	30.76	32.86
37...	28.84	31.11	31.65	32.82	29.87	31.36	27.44	30.16	27.32	29.43
42...	25.87	27.70	27.74	28.86	26.33	27.71	23.94	26.37	23.96	25.92
47...	22.66	24.13	23.92	24.96	22.82	24.05	20.56	22.68	20.66	22.32
52...	19.35	20.58	20.21	21.20	19.40	20.48	17.31	19.13	17.42	18.83
57...	16.19	17.20	16.75	17.61	16.16	17.12	14.30	15.83	14.45	15.59
62...	13.24	14.01	13.52	14.26	13.17	13.99	11.67	12.91	11.78	12.62
67...	10.52	11.10	10.67	11.32	10.48	11.13	9.37	10.35	9.27	10.07
72...	8.25	8.68	8.30	8.82	8.11	8.64	7.37	8.15	7.22	7.93
77...	6.32	6.64	6.29	6.69	6.09	6.54	5.73	6.28	5.74	6.05
82...	4.76	5.00	4.72	4.98	4.54	4.89	4.44	4.77	4.22	4.46
87...	3.60	3.72	3.66	3.73	3.39	3.63	3.48	3.66	2.51	3.06
92...	2.76	2.72	2.81	2.82	2.54	2.67	2.79	2.82	1.19	1.87
97...	2.09	2.07	2.17	2.18	1.88	1.94	2.16	2.20	*	*

*Not computed.

One way of summarizing this situation, perhaps a rather gruesome way, is to say that we could afford to have constantly with us an epidemic as severe as that of 1918, and yet, *as regards mean length of life*, we would be practically no worse off than the population of the original registration states actually was from day to day in 1901. But one important fact must not be overlooked in this con-

nection. The growth or maintenance of the population depends, it is true, on the one hand, on the mean length of life; but it depends also on the birthrate. While a mean length of life of forty-seven years for white males would have sufficed to maintain the population under the conditions prevailing in 1901, today, with our decreased birthrate, it would no longer be sufficient; for the birthrate required to maintain a population with a mean length of life of forty-seven years is the reciprocal of forty-seven, namely, .021, or twenty-one per 1,000 per annum. The birthrate for 1928 has recently been reported as only 19.7, and would therefore be quite inadequate.

It throws an interesting light on the progress of public health to reflect that the influenza pandemic, in its effect on mortality, was virtually equivalent to a momentary setting back of the clock by about twenty years. Our advance in health conditions in the first two decades of the twentieth century thus corresponded approximately to the elimination, from our death toll, of a constant drain about equivalent to that exacted in 1918 by the influenza epidemic.

The table on page 2 shows the expectation of life at several ages, as computed according to the mortality of 1918, and, for comparison, according to several other life tables referred to in this article.

HEALTH PROGRESS IN THE PROVINCES OF CANADA

Health conditions in Canada are, in general, about the same as in the United States. This is indicated by a mortality rate of 8.9 per 1,000, in 1928, for about one and one-quarter million Canadians insured in the Industrial Department of the Metropolitan Life Insurance Company, as compared with a rate of 8.1 for the millions of insured white persons in the United States. But the several provinces of Canada show very marked variations in their death rates. In each of the four western provinces (Manitoba, Saskatchewan, Alberta and British Columbia) the condition of the public health is extraordinarily good, as would be expected with relatively new and prosperous populations. In Ontario, also, the mortality rate averages well under that for white persons in the United States. It is due entirely to the much higher deathrates in Quebec, New Brunswick and Nova Scotia that the mortality for Canada, as a whole, is a little higher than in the United States. It is in these three provinces that the more serious health problems of Canada are largely centered.

It is the high prevalence of diseases associated with primitive sanitation that accounts for the high deathrates in the three provinces. Typhoid fever, measles, diphtheria, tuberculosis, pneumonia and the

diarrheal complaints are conspicuous examples. These conditions are, fortunately, subject to control and therein lies the promise for future health progress in Canada.

In New Brunswick the deathrate, in 1928, was 10.0 per 1,000 as against 8.9 for Canada as a whole. The epidemic diseases of childhood, tuberculosis, cancer, heart disease, pneumonia, diarrheal diseases and accidents are important factors in the higher mortality. New Brunswick had the highest deathrate of any Canadian province, in 1928, from measles, diphtheria, cancer, pneumonia and accidents. Its tuberculosis deathrate was exceeded only in Quebec and Nova Scotia. Virtually the same conditions exist in Nova Scotia as in New Brunswick. Nova Scotia, in 1928, registered the maximum rates, in all Canada, for whooping cough, cerebral hemorrhage, puerperal diseases, and except Quebec, for tuberculosis. Almost one-seventh of all deaths in the Province were due to tuberculous disease.

Quebec registers the highest general deathrate of any Canadian province. Year after year, above-average mortality occurs from typhoid fever, the epidemic diseases of childhood, tuberculosis, pneumonia and other respiratory diseases, and more particularly, diarrheal complaints and chronic nephritis. Diarrheal complaints are actually the chief cause of death in the Province causing almost one-sixth of the entire mortality. The tuberculosis deathrate and that for respiratory diseases other than pneumonia, are also higher than elsewhere in Canada. For chronic nephritis, the deathrate runs about one-third higher than the average for Canada. This does not obtain, however, for the other "degenerative" conditions, cerebral hemorrhage and organic heart disease. Something in the environmental conditions of the French Canadian population apparently operates to bring about a very high deathrate from chronic kidney disease.

Recent plans of the Provincial health authorities in Quebec, however, justify the hope that improvement will soon be registered in the mortality of the Province. Plans have been perfected for the organization of full-time county health units in all parts of the Province. In fact, greater progress has been made in this regard in Quebec than in any other province of the Dominion. In the summer time, the emphasis of the service is laid upon improving conditions for mothers and children. During the winter the health staffs visit the schools. The health units are all located in the larger towns and their influence radiates to all parts of the counties. It is hoped that the aid of the clergy will be enlisted in the health campaign,

and that this will be a powerful factor in bringing about better sanitary conditions, and consequently, longer life in Quebec.

The new health movement enjoys the cordial support of the Government and the people of Quebec and has received the cooperation of the Rockefeller Foundation and the Metropolitan Life Insurance Company.

The following table shows the 1928 deathrates for the more important diseases among Metropolitan Industrial policyholders in Canada, and for each of the eight Provinces:

Deaths and Deathrates per 100,000 from Principal Causes. All Ages. Total Canada and Each Province. Year 1928. Metropolitan Life Insurance Company. Industrial Weekly Premium-paying Business.

Cause of Death	Deathrates per 100,000								
	Total Canada	Quebec	Ontario	Alberta	British Columbia	Manitoba	New Brunswick	Nova Scotia	Saskatchewan
All Causes	892.3	1080.2	722.7	565.1	511.2	538.8	1003.6	924.1	551.3
Typhoid fever	5.9	9.0	2.1	12.0	.....	2.4	11.9	1.9	5.2
Measles	5.9	7.1	3.1	4.0	1.7	.....	23.8	13.4	.....
Scarlet fever	6.8	11.2	2.8	4.0	3.5	.....	5.9	.....	5.2
Whooping cough	8.9	10.5	6.7	.....	3.5	4.8	8.9	25.0	.....
Diphtheria	21.5	28.3	13.6	12.0	14.0	14.4	44.5	17.3	5.2
Influenza	34.2	43.9	25.9	36.1	8.7	19.2	17.8	32.7	36.1
Tuberculosis—All forms	95.2	131.8	52.3	36.1	55.8	47.9	98.0	126.8	41.2
Tb. of the resp'y system	76.8	108.2	43.3	20.0	34.9	35.9	65.3	98.0	30.9
Cancer	61.3	56.9	69.0	20.0	52.3	38.3	89.1	82.6	36.1
Diabetes	11.3	11.2	12.3	16.0	7.0	12.0	8.9	7.7	10.3
Cerebral hemorrhage	32.8	27.6	40.5	24.0	38.4	19.2	20.8	48.0	20.6
Organic diseases of heart	80.1	74.8	91.5	84.2	57.6	64.7	86.1	67.2	67.0
Pneumonia—All forms	88.5	110.7	71.0	48.1	26.2	45.5	112.8	84.5	77.3
Other respiratory diseases	23.4	33.5	14.9	16.0	5.2	14.4	14.8	21.1	5.2
Diarrhea and enteritis	96.1	159.0	42.8	32.1	12.2	9.6	65.3	38.4	41.2
Chronic nephritis	36.4	50.5	25.6	12.0	17.4	7.2	23.8	25.0	30.9
Puerperal state	16.1	15.6	14.9	4.0	15.7	14.4	20.8	34.6	5.2
Suicides	2.8	1.1	5.4	.....	.....	9.6	5.9	.....	.....
Homicides	.8	.7	.8	.....	1.7	2.4	.....	1.9	.....
Other external causes (excluding suicides and homicides)	53.0	48.7	56.1	40.1	48.8	31.1	86.1	80.7	30.9
Traumatism by automobiles	10.6	9.0	13.8	8.0	8.7	7.2	5.9	11.5	5.2
All other causes	211.2	247.5	171.5	164.3	141.3	182.0	258.3	215.2	134.0

FURTHER FACTS ON ACCIDENTAL FALLS

Nearly one-half of the deaths from falls among Metropolitan Industrial policyholders for the three years, 1926 to 1928, occurred in the home. One-third of the fatal falls on domestic premises were on stairs. Every tenth fatal fall in the home was out of the window. Slipping or falling on floors accounted for one out of every eight falling fatalities in the home. Falling out of bed or falling over

chairs each contributed one-twentieth of the total mortality from falls in the home. Among women, nearly two-thirds of the falls recorded in these three years occurred in the home.

Falls in public places comprised 19.0 per cent. of the total mortality from this cause, and 43 per cent. of these deaths in public places arose in the pedestrian use of streets and sidewalks. Among males, 23 per cent. of the falls were in public places and among females only 14 per cent.

Risks incidental to employment accounted for 15 per cent. of all fatal falls; for 25 per cent. of those among males and for less than 1 per cent. of the falls among females. Nearly 10 per cent. of the falls in industry occurred in building construction, 21 per cent. from scaffolds and staging, 9 per cent. from ladders, 6 per cent. from roofs, 5 per cent. from windows, and 4 per cent. into holds of ships or on ships.

The detail for deaths from falling are given in the table below and on page 7.

Fatal Accidental Falls, 1926-1928. By Origin of Hazard. Metropolitan Life Insurance Company, Industrial Department

Origin of Hazard	Total		Males		Females	
	No. of Deaths	Per Cent. of Total	No. of Deaths	Per Cent. of Total	No. of Deaths	Per Cent. of Total
Total Accidental Falls..	4,343	100.0	2,596	100.0	1,747	100.0
Industrial.....	669	15.4	660	25.4	9	.5
Public.....	826	19.0	587	22.6	239	13.7
Transportation.....	13	.3	11	.4	2	.1
Sports and recreation...	46	1.1	41	1.6	5	.3
Pedestrian use of streets.	348	8.0	216	8.3	132	7.6
Use of public buildings..	131	3.0	80	3.1	51	2.9
Other public accidents..	288	6.6	239	9.2	49	2.8
Domestic.....	2,001	46.1	851	32.8	1,150	65.8
Origin of hazard not specified.....	847	19.5	498	19.2	349	20.0

This information has been compiled and published as an indication of the type of information which will become available when present plans of the National Safety Council and the Section on Vital Statistics of the American Public Health Association for the development of accident statistics in the United States are perfected and applied. The toll of fatal accidents in the United States bids fair to reach 100,000 each year and the identification of the main

factors responsible for this high and rising mortality depends in part upon securing data which will tend to identify hazard factors and point to their control. The International List of Causes of Death provides at present no way to determine where hazardous situations exist, nor is there much information available on the particular modes of injury which produce death. It is hoped that registrars of vital statistics for our states and cities will cooperate with the American Public Health Association Committee (Dr. W. THURBER FALES, State Registrar of Vital Statistics, Montgomery, Alabama, Chairman) in considering plans for throwing further light on a serious and growing menace to life in this country.

Fatal Accidental Falls, 1926 to 1928. By Means of Injury and Origin of Hazard. Metropolitan Life Insurance Company, Industrial Department

MEANS OF INJURY	TOTAL		INDUSTRIAL		PUBLIC		DOMESTIC		ORIGIN OF HAZARD NOT SPECIFIED	
	No. of Deaths	Per Cent. of Total	No. of Deaths	Per Cent. of Total	No. of Deaths	Per Cent. of Total	No. of Deaths	Per Cent. of Total	No. of Deaths	Per Cent. of Total
TOTAL ACCIDENTAL FALLS	4,343	100.0	669	100.0	826	100.0	2,001	100.0	847	100.0
Balcony, porch	146	3.4	2	.3	3	.4	134	6.7	7	.8
Bed	111	2.6	.....	.....	7	.8	104	5.2	.....	.....
Building under construction	68	1.6	64	9.6	3	.4	1	*	.....	.....
Chair	103	2.4	1	.1	1	.1	98	4.9	3	.4
Fire escape	42	1.0	1	.1	2	.2	38	1.9	1	.1
Hold of ship, or on ship	28	.6	26	3.9	2	.2	.....	.....	.....	.....
Ladder	113	2.6	63	9.4	4	.5	24	1.2	22	2.6
Roof	113	2.6	43	6.4	6	.7	57	2.8	7	.8
Stairs	951	21.9	22	3.3	40	4.8	666	33.3	223	26.3
Tree	52	1.2	13	1.9	36	4.4	1	*	2	.2
Scaffold, staging	146	3.4	138	20.6	6	.7	1	*	1	.1
Street	372	8.6	5	.7	356	43.1	8	.4	3	.4
Window	293	6.7	31	4.6	27	3.3	204	10.2	31	3.7
Floor	308	7.1	7	1.0	24	2.9	270	13.5	7	.8
Other specified means	727	16.7	207	30.9	261	31.6	186	9.3	73	8.6
Means not specified	770	17.6	46	7.2	48	5.9	209	10.6	467	55.2

*Less than .05 per cent.

A PLAN FOR BETTER STATISTICS ON CANCER

More medical research is obviously called for if the growing movement for the control of cancer is to succeed. The American Society for the Control of Cancer and the American Public Health Association have joined forces in planning the direction which

statistical research should take, and will hold a joint session for the discussion of these matters at the next annual meeting of the American Public Health Association at Minneapolis, in October. The session will be a feature of the program of the Health Association's Section on Vital Statistics.

The American Society for the Control of Cancer has designated three speakers, each of whom is an outstanding leader in its organization, to address the joint session. Dr. FRANCIS CARTER WOOD, Director of the Crocker Institute for Cancer Research, Columbia University, will speak on "The Need for Cancer Morbidity Statistics;" Dr. H. E. ROBERTSON of the Mayo Foundation, Rochester, Minnesota, will talk about "The Problems of Cancer Mortality Statistics." The subject to be discussed by Dr. W. A. EVANS, former Health Commissioner of Chicago, and one time President of the American Public Health Association, will be "How to Give Cancer Statistics a Greater Popular Appeal." The discussion of these addresses will be led by vital statisticians of recognized ability and standing. Dr. FREDERICK L. HOFFMAN, Consulting Statistician of the Prudential Insurance Company of America, will lead the discussion of Dr. WOOD's address; Dr. J. V. DEPORTE, Director of the Division of Vital Statistics, New York State Health Department, and Dr. JEROME MEYERS of the New York City Health Department, will discuss Dr. ROBERTSON's paper, while Dr. HAVEN EMERSON of the Department of Public Health Administration, Columbia University, will open the discussion of Dr. EVANS' address.

The vital statisticians, who represent federal, state, municipal and corporate statistical departments, believe that there is much to be gained by having the leading organization whose interest lies in the control of cancer point out possible new lines of statistical study. It is hoped by both organizations, that as an outgrowth of their joint session, new information about cancer will be brought out, which, in turn, will lead to still more intensive investigation of important aspects of the cancer problem.

HEALTH RECORD FOR JULY, 1929

The deathrate for July among the Metropolitan Industrial policyholders was 8.2 per 1,000. This is the approximate average for that month during the current decade, and is identical with the figure for July, 1928, and for June, 1929. The cumulative deathrate for the seven months' period, January-July, was 10.0 per 1,000, or only 3.1 per cent. higher than for the corresponding part of 1928.

How markedly health conditions have improved, since the early months of the current year, is shown by the fact that at the end of February the cumulative deathrate was 31.9 per cent. in excess of the figure for the first two months of 1928. The year-to-date rate at the end of July, in the section of the United States west of the Rocky Mountains, was 7.1 per 1,000 as compared with 6.9 in 1928. In the remainder of the United States the corresponding figures were 10.2 and 9.9. These are relatively small increases, but among Canadian policyholders an increase of 5.6 per cent. was registered.

Three of the four principal epidemic diseases of childhood recorded lower deathrates than in July of last year. Declines were also in evidence for influenza, organic heart disease, pneumonia, other respiratory conditions, diarrheal diseases, suicides and homicides. On the other hand, the July deathrates for typhoid fever, tuberculosis, diabetes and puerperal conditions were slightly higher than in the same month last year and those for cancer, cerebral hemorrhage, Bright's disease, accidents and automobile fatalities were markedly higher.

The outstandingly favorable item in the year's health record, to date, is the further decrease in the mortality from tuberculosis. The cumulative deathrate at the end of July was nearly 4 per cent. below the previous low record for any corresponding period—established only last year. Next in importance is the further reduction in deaths from diphtheria. There is every reason to believe that these two diseases will establish new minimal deathrates in 1929. Diarrheal complaints and puerperal conditions also bid fair to establish new low points in 1929.

On the other hand, the cancer deathrate continues its persistent rise. That for diabetes is well above the previous maximum, and cardiac diseases have caused many more deaths than in the January-July period of last year.

Three hundred and sixty-five Industrial policyholders were killed in automobile accidents during July, the deathrate reaching the very high figure of 22.6 per 100,000. The cumulative deathrate for automobile fatalities at the end of July was 17.6 per 100,000 or, 12.8 per cent. in excess of that for the corresponding period of 1928.

The deathrate for the general population of the large cities of the United States in July was 10.7 per 1,000 population. This is lower than for the previous month (11.9) and for July, 1928 (11.2). More cases of poliomyelitis and typhoid fever were reported than for June, but diphtheria, influenza, measles, scarlet fever and smallpox were

less prevalent. A comparison with July, 1928 shows higher incidence of measles, influenza, poliomyelitis and typhoid fever, with fewer cases of diphtheria, scarlet fever and smallpox.

Diphtheria cases, during the first four weeks of July numbered 3,461, in 30 states, as against 4,475 during the like period of June. Measles cases, in 31 states, numbered only 13,509 as compared with 42,681, in June. Only 4,695 scarlet fever cases were reported, in July, from 35 states, against 11,533 in June. Poliomyelitis, however, was nearly twice as prevalent in July as in June, according to reports from 45 states. In New York the increase was from 11 cases to 39; in North Carolina, from 7 to 35; in Tennessee, from 2 to 20, and in South Carolina, from 4 to 10.

There were a number of important developments of public health interest during July. President HOOVER called a White House conference on the health and protection of children at which representatives of the great voluntary health agencies as well as Federal, state and municipal authorities were in attendance. The UNITED STATES CHAMBER OF COMMERCE has announced a health conservation contest open to local chambers of commerce throughout the country. The COMMONWEALTH FUND OF NEW YORK is to develop a programme for seeking ways to make the rural districts of the country as up-to-date in health work as the cities. Public health service and medical practice generally will be strengthened in two states which have a large rural population and which will be selected shortly. These two states will be used as a nucleus for developing sound rural health programmes which, later, may be used as models for other states.

The following table shows the mortality among the Industrial policyholders for July, 1929; June, 1929, and July, 1928, together with the cumulative rate for the first seven months of each year:

METROPOLITAN LIFE INSURANCE COMPANY

Deathrates* per 100,000 for Principal Causes, Premium-paying Business in Industrial Department (Annual Basis)

MONTHS OF JULY, 1929; JUNE, 1929, AND OF JULY, 1928

CAUSES OF DEATH	RATE PER 100,000 LIVES EXPOSED*				
	July, 1929	June, 1929	July, 1928	Cumulative January to July	
				1929	1928
TOTAL—ALL CAUSES	822.0	816.1	817.6	997.7	966.1
Typhoid fever	3.2	2.4	2.8	1.9	2.0
Measles	2.7	4.8	5.1	4.2	8.1
Scarlet fever	2.4	2.2	2.0	3.2	3.5
Whooping cough	5.8	4.7	5.9	6.2	6.2
Diphtheria	6.5	7.5	7.1	9.1	10.8
Influenza	5.2	9.9	10.0	62.1	29.5
Tuberculosis (All forms)	86.9	86.7	84.1	92.0	95.8
Tuberculosis of resp'y system	75.8	75.7	73.6	81.5	83.9
Cancer	78.5	73.5	70.7	76.5	75.4
Diabetes mellitus	15.4	13.8	14.8	19.8	18.6
Cerebral hemorrhage	53.1	50.0	48.6	59.8	59.1
Organic diseases of heart	123.4	130.1	129.1	156.8	150.2
Pneumonia (All forms)	39.3	61.1	49.8	111.3	111.7
Other respiratory diseases	8.4	11.1	14.0	13.4	14.6
Diarrhea and enteritis	20.4	16.3	27.3	15.0	17.7
Bright's disease (Chronic nephritis)	62.4	60.0	58.5	72.2	74.1
Puerperal state	14.4	11.1	13.1	14.2	14.4
Suicides	7.9	8.0	8.0	8.6	8.4
Homicides	6.1	6.2	6.2	6.2	6.4
Other external causes (excluding suicides and homicides)	79.0	63.9	72.0	61.5	59.3
Traumatism by automobiles	22.6	19.2	16.1	17.6	15.6
All other causes	201.2	192.8	188.4	203.7	200.4

*All figures include infants insured under one year of age.

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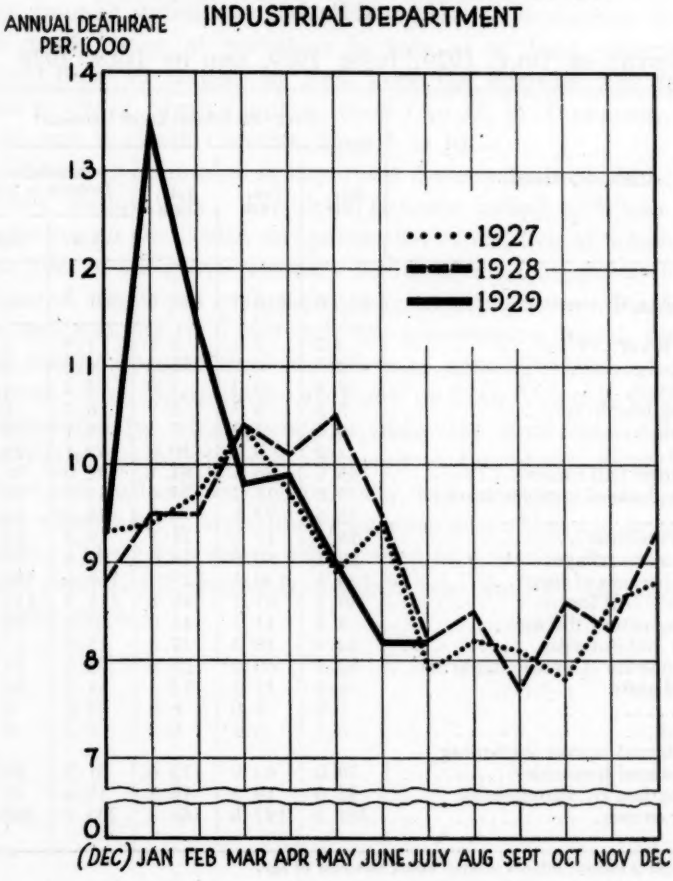
DEATHRATES
FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE CO.
INDUSTRIAL DEPARTMENT



1927	9.4	9.7	10.4	9.7	8.9	9.4	7.9	8.2	8.1	7.8	8.6	8.8
1928*	9.5	9.5	10.4	10.1	10.5	9.5	8.2	8.5	7.7	8.6	8.3	9.3
1929	13.4	11.4	9.8	9.9	9.0	8.2	8.2					

* Rates for 1928 are final

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